**CONSUMER REFERRAL**

*\*Please note if crisis assistance is required, please contact Emergency Services on 000 or your local Mental Health Service Acute Care Team.*

| **Referral Date:**  |  | **Client or Parent/Guardian/Carer consent for this referral** *(if aged 12-18):*☐ Yes ☐ No  |
| --- | --- | --- |
| **Referral Type** | ☐ Workcover ☐ Employee Assistance Program (EAP) ☐ Other  |
| **Service Location:** | ☐ Rockhampton ☐ Thursday Island ☐ Nambour ☐ Other *(Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| **REFERRER DETAILS** |
| **Name of referrer:** |  | **Organisation:** |  |
| **Referrer position/ profession:** |  | **Provider number:** *(if applicable)* |  |
| **Phone:** |  | **Email:** |  |
| **Address:** |  | ☐ **Experiencing homelessness** |
| **CONSUMER DETAILS:** |
| **Name:**  |  | **Preferred Name**  |  |
| **D.O.B.** |  | **Gender:** |  |
| ☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **Both** ☐ **Neither** | ☐ **Culturally & Linguistically Diverse Background** |
| **Address:** |  |
| **Phone numbers:** |  |
| **Email:**  |  |
| **Parent/Carer/****Guardian Name:** *(if aged 12-18)* |  | **Relationship to youth:** |  |
| **Contact details:** |  |
| **ADDITIONAL INFORMATION:** |
| **Reason for Referral:**  |  |
| **Consumers goals and hopes:**  |  |
| **Key Issues identified by consumer and worker:** | * Psychological support
* Physical health
* Housing/Accommodation
* Substance use
* Financial
* Employment
 | * Relationships
* Domestic & Family Violence
* Social
* Education
* Isolation
 | * Other:
 |
| **Mental Health Diagnosis:** *(if applicable)*  |  |
| **Mental Health Care Plan completed:**  | ☐ Yes *(please attach)* ☐ No |
| **Medication details:** *(if applicable)* |  |
| **Outcomes/scores of any relevant psychosocial assessments:** (*e.g. K5, K10, SDQ*) |  |
| **Risk of harm to self:** | Is the person currently self-harming ☐ Yes ☐ NoIs the person at increased risk of suicide ☐ Yes ☐No *\*If assessed at high risk of suicide please contact Emergency Services on 000 or Mental Health Service Acute Care Team* |
| **Are there any risk factors we should be aware of?**  | ☐ No ☐ Yes *(please specify below or attach existing risk assessment)* |
| **Other services consumer is accessing:**  |  |
| **Other relevant information:**  |  |
| **CONSUMER PREFERENCES** |
| **Preferred Gender of Worker:** | ☐ Female ☐ Male |
| **Preferred contact method:** | ☐ Mobile ☐ Home phone \*Ok to leave voicemail/send SMS: ☐ Yes ☐ No☐ Email ☐ via Referrer ☐ Home visit  |
| **Other preferences:** |  |

**This form can be delivered to Wakai Waian Healing by:**

**For the Rockhampton and Nambour offices or Other locations please send to:**

**Fax:** (07) 4829 4011

**Email:** referralscq@wakai-waian.com.au

**Postal:** PO Box 4080, Rockhampton,QLD,4700

**In person:** 104 Fitzroy Street, Rockhampton QLD, 4700

**For the Thursday Island Office please send to:**

**Fax:** (07) 4829 4011

**Email:** referralsti@wakai-waian.com.au

**Postal:** P.O. Box 767, Thursday Island, QLD, 4875

**In person:** Unit 3, 40 Douglas St, Thursday Island QLD, 4875

**Further Information:**

Freecall: 1800 732 850 or Email: enquiries@wakai-waian.com.au